	T OF DEFICIENCIES OF CORRECTION	PROVIDER IDENTIFICATION NUMBER:	MULTIPLE BUILDING:	CONSTRUCTION	DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER	060064 ER ADVENTIST HOSPITAL	2525	T ADDRESS, CITY, STATE, ZIP CODE S DOWNING ST /ER 80210	04/17/2018	
ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	COMPLETION DATE
H 000	Initial Comments A survey prompted	bter IV General Hospitals by complaint #CO21404 and mpleted on 4/17/18. cited.	H 000			
H 503	Sufficient supportir assigned to the se	Supplies: Personnel ng personnel shall be rvice and properly trained in rgical supply services.	H 503			06/27/201
	Based on observat document review, to oversight and ensure the sterile procession maintained to ensure sterilization process required. Furtherm the failure in sterile evidence of training avoid further incide failure resulted in the contaminated surgeroom staff for use in Findings include: Facility Policy: The Sterile Procession and objects to be step thoroughly cleaned.	sing Procedures policy read, erilized must first be I to remove all bio-burden and uments are to be inspected are clean, dry and		Person Responsible: The Governing Body will have usesponsibility for all corrective a ongoing compliance associated requirements, however the Chie Officer) CNO and Chief Medical (CMO) provide direct oversight. The CNO and CMO collaborate regarding when the Sterile Proceeding affected the availability of sterile instruments scheduled surgeries. The Periop Services Director has direct over the Sterile Processing Manager responsible for the operational of the SPD. Actions: 1. The Governing Board has for responsibility for determining, implementing and monitoring the Hospital's total operations and owith its policies and procedures.	altimate ctions and with these of Nursing Officer dessing error of the certive ersight of the coversight who is expressing the compliance error of the certification of the certi	
	References:			The Governing Board was in the outcome of accreditation su		

I attest that the plan of correction will be implemented and monitored for compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PROVIDER IDENTIFICATION NUMBER:			MULTIPLE BUILDING:	CONSTRUCTION	DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER RA HEALTH-PORTE	ER ADVENTIST HOSPITAL	2525	T ADDRESS, CITY, STATE, ZIP CODE S DOWNING ST /ER 80210		
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H 503	According to the As Registered Nurses Perioperative Prace Recommendation I be thoroughly clean before high-level didecontamination as steps in breaking the transmission. Debrand organic matter of the disinfectant. Recommendation I items are contaminincluding bacterial substantial. Examp surgical instrument Recommendation I team members with and care of instruments complete competer relate to cleaning a instruments. Ongoi competency valida personnel facilitate knowledge, skills, a patient and worker Recommendation I instruments should for cleanliness after soiled should be reare cleaned. Items patient at risk for in (SSI). Use of instruction cleaned, poses a risk to the competency equipment of the competency cleaned, poses a risk for in (SSI). Use of instruction instruction instruction in the competency cleaned	ssociation of periOperative (AORN), Guidelines for tice, 2017: I (Page 801), Items should ned and decontaminated sinfection. Cleaning and re the initial and most critical ne chain of disease is, blood, mucus, fat, tissue, will interfere with the action (Page 801), When critical lated with microorganisms, spores, the risk of infection is less of critical items are is. KV (Page 841), Perioperative in responsibilities for cleaning nents used in surgery should ongoing education and incy verification activities and care of surgical ing education and tion of perioperative the development of and attitudes that affect	H 503	occurring 2/20/18 forward, via pheand meetings. The Governing Eregular meetings and conference late February forward, to discussion survey findings and the plans of correction. 3. The Governing Board meets and as necessary to discuss own operational and patient care issurelated but not limited to, Sterile Processing Department personn Hospital leadership worked closs Centura corporate leadership to with correction of survey finding implementation of processes to compliance. 4. Immediate SPD staffing pland developed to address variances levels, immediate staffing needs considered skill sets required, so volume and instrument inventors developed to staff SPD, 2/23/18 levels reviewed, new SPD staffing developed with consideration of volume times, staff skill sets and instrument availability; staffing in by 7 FTE positions, 2/28/18. An and balanced staffing across sh accordance with work volume. The includes at least 2 individuals staffing developed with consideration of volume times, staff skill sets and instrument availability; staffing in by 7 FTE positions, 2/28/18. An and balanced staffing across sh accordance with work volume. The includes at least 2 individuals staffing developed to case volumes. 5. Emergency shift bonus pay on 2/21/18 to assist with immediate staffing requirements. Meetings Corporate resources to assist with immediate staffing requirements. Meetings Corporate resources to assist with immediate staffing requirements.	soard held e calls, s the s monthly erall ues, nel. ely with assist s and sustain n in staffing and urgical /, Staffing ng matrix peak l ncreased alyzed iffs in his affed in load, staffing ling d" staffing ling d" staffing eek, in instituted ate to identify	

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STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	PROVIDER IDENTIFI	CATION	MULTIPLE CONSTRUCTION BUILDING:		DATE SURVEY COMPLETED	
	060	064			04/1	7/2018
NAME OF PROVIDER OR SU CENTURA HEALTH-I	PLIER ORTER ADVENTIST I	HOSPITAL	2525 S	ADDRESS, CITY, STATE, ZIP CODE S DOWNING ST ER 80210		
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Department 1/19/17 to 2/interview wit #8, on 2/28/contained dawere compled discovered ato the operation CNS #8 the the SPD material state of the SPD material state of the SPD material state of the SPD staff incidents of sterilization blood, and concerns with 2/9/18. From 1/19/11 reported incontamination on 1/24/17 of pan. On 1/24/17 of pan. On 2/16/17 of instrumentation 3/8/17 viste pan. On 3/27/17 instrumentation on 3	personnel. If the Sterile Processing SPD) Case Reports look 2/18 was conducted. Do not clinical Nurse Special 8 at 1:51 p.m., she state ta from SPD case reported by operating room in issue after the tray wing room (OR) suite. Accepts were sent down ager created the log. If Case Report log reverse members had one or in locumented contaminal process which included ement. As example, ssing Technician (SPT cumented incidents inventages processed from trays processed from the strong within a surgical nunks of bone found incidents in the ement was found on the one incident was found on the oburden was found with the strong processed from the strong within a surgical nunks of bone found incidents in the processed from the strong within a surgical nunks of bone found incidents was found on the one and blood we strong within a surgical processed from the strong within a surgical nunks of bone found in the contamination of the strong was found with	g, from uring an list (CNS) ed the log orts which staff who as delivered ecording to to SPD and aled 17 of nore tion after the bone, hair,) #13 had a volving 1/19/17 to ad 17 ere al tray (pan). side of the e ere found in hile in a hite nt used for /28/17, SPT tion. Review	H 503	immediate response, 2/22-23/18 6. Ongoing collaboration contice Centura, the hospital's corporate resources department, to active and identify qualified SPD technone SPD technician was hired a 4/24/18. 2 additional fulltime SP technicians will begin on 5/14/18 technicians will complete orienta 120 days, per policy. 7. Contracted agency supplies experienced and competent SPI technicians; 8 open positions fill Travelers began 3/5/18 and are contracted through 7/12/18. 8. Experienced SPD Leads/Su were identified and scheduled, s 4/13/18, to provide 24/7 oversign decontamination and sterilization processes. 9. An experienced Interim Peri Director identified on 3/4/18, to resigning Director 3/23/18. Interileadership structure created. Of specifically focuses on the opera oversight and accountability of the processes and staffing to ensure sterile instruments are ready and for scheduled cases. The other focuses primarily on OR process operations. Position for Perioper Director posted 3/19/18. 10. The Perioperative Services notifies senior leadership when its SPD staffing may result in unavainstrumentation for scheduled processes. The OR schedule maadjusted, as needed - Ongoing.	nues with e human ly recruit icians. as of D 3. New ation in 90-ed. currently spervisors starting at of n spervisors starting at spervisors starting at of n spervisors starting at of n spervisors starting at of n spervisors at of n sper	

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of cement found on instruments.

handle was noted.

On 2/22/17 an incident of blood on a knife

On 5/30/17 bone was found in the bottom of a

Printed: 06/07/2019 Health Facilities and Emergency Medical Services Division MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES PROVIDER IDENTIFICATION DATE SURVEY AND PLAN OF CORRECTION NUMBER: COMPLETED BUILDING: 060064 04/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2525 S DOWNING ST CENTURA HEALTH-PORTER ADVENTIST HOSPITAL **DENVER 80210** COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION DATE **PREFIX** (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 503 Continued From page 3 H 503 warning was issued for SPD#13's failure to 11. An experienced Interim SPD Manager meet the performance expectations of his was hired through contracted agency, position. Specifically, on 3/23/17 dirty Kerrisons starting 4/10/18, to manage staffing and (spinal surgical instruments) were found in an oversee sterilization processes. The instrument set during a surgical case. The form Interim SPD Manager reviews all noted on 3/7/17 the employee had received a occurrences and ensures staff is verbal warning regarding dirty instrumentation in coached/trained and that corrective action instrument sets. is taken when appropriate. The Interim SPD Manager reports staffing issues that impact ability to process instrumentation After the corrective action SPT #13 had 11 additional case reports that involved needs, to the Perioperative Services contaminated trays. As example, Director. On 6/29/17 OR staff documented a dead bug 12. Position for SPD Educator posted was found in the surgical tray. 3/19/18 and an interim educator was On 8/1/17 and 8/9/17 cement was found on the hired, starting 5/29/18. The SPD cement gun (surgical instrumentation). Educator assists with ongoing continuing On 8/28/17 crusty blood or tissue was found on education and competency assessment of a surgical instrument. SPD staff. On 9/6/17 cement was found on an instrument. On 11/22/17 blood from a previous surgical case was found on a piece of an instrument. Compliance and Monitoring: 1. Monitoring of completion of On 3/1/18 at 7:06 a.m., an interview with SPT # counseling/corrective action in relationship 13 was conducted. SPT #13 stated SPD staff to each identified failure. Numerator = were currently recleaning, repackaging, and number of corrective actions documented resterilizing every instrument in the department related to failures monthly; Denominator = due to a recent incident in which surgical number of occurrence reports related to instruments were delivered to the OR suite SPD process fall-out occurrences which were not "up to standards" due to the monthly, with a goal of 100% compliance. "amount of bioburden" on them. Ongoing retraining and competency b. Continued review of the Case Report log completion rate, for any SPD and OR staff revealed SPT #18 had 12 incidents from 1/19/17 not included in the initial training, is 100%. to 2/9/18 of documented contamination after the sterilization process; such as cement, bone and 3. Rate of completion of new-hire hair found on instruments or inside the tray. competencies by 90-120 days, per policy, for associates starting in February 2018, Specifically: forward. This will be monitored monthly On 1/19/17 two separate documented incidents for 4 months and quarterly thereafter.

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4. Daily monitoring of available SPD staff matching the staffing plan. Numerator =

number of available SPD staff:

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department (SPD) employees were identified on the case report logs which identified similar findings of contamination, including bone, hair,

There was no documentation the SPD staff

blood, and cement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PROVIDER ID NUMBER:		PROVIDER IDENTIFICATION NUMBER:	MULTIPLE (BUILDING:	CONSTRUCTION	DATE SUR\ COMPL	
		060064			04/	17/2018
	ROVIDER OR SUPPLIER	TER ADVENTIST HOSPITAL	2525 S	ADDRESS, CITY, STATE, ZIP DOWNING ST ER 80210	CODE	
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H 503	Continued From	page 5	H 503			
	evaluated to ensu	nd had their competency ure contaminated instruments cleaned, processed, and				
	SPD Manager #3 stated "we are sh processing instru which he conside "I don't have enou	0:27 a.m. an interview with was conducted. Manager #3 ort staffed" and we're currently ments for up to 50 cases a day red to be "not safe." He stated ugh staff" and the sterile tment was "severely short				
	contaminated tray operating room re process had beer did not have time staff completed the prior to the instruistated he had to completed by OR trays or instruments.	d he was aware there were still as being delivered to the ecently after the sterilization in completed. He reported he to audit instruments after SPD in the precleaning process and ments being sterilized. He wait for an incident report to be staff to identify contaminated ints. Manager #3 stated he did audit SPD staff performance.				
	11/16/16, stated h development and coaching and trai employee perforn completed work a techniques; and in	er #3's job description, signed is duties included: identify staff training needs and provide ning; evaluate and verify nance through the review of assignments and work nivestigate and work to resolve sk management issues.				
	10:07 a.m., Mana was too understa perform manager monitoring occurr	gent interview, on 2/28/18 at ger #3 again stated the SPD ffed for him to be able to duties such as audits, ences, orienting new staff and ng training and education for				
	According to Man	ager #3 there was only one				

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	T OF DEFICIENCIES OF CORRECTION	PROVIDER IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION BUILDING:		DATE SURVEY COMPLETED	
		060064			04/17	7/2018
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ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
H 503	Continued From pa	age 6	H 503			
	staff member with case reports who received any corrective action. Manager #3 further stated none of the SPD staff members received any re-education or training on sterilization processes.					
	Manager #3 stated department becam normal staff in-serv education was com	iew, on 2/28/18 at 10:07 a.m., I the sterile processing the too busy to schedule vices and all staff training and impleted and documented the conducted at the beginning				
	On 2/28/18 at 3:17 p.m., the sterile processing department director, (Director #4), who had oversight of the SPD department and supervised Manager #3 was interviewed. Director #4 stated shift reports were detailed verbal team meeting discussions and all staff were expected to read and sign to ensure staff had received the education. However, review of the daily shift reports, dated 11/8/17 through 2/20/18, revealed multiple dates in which no shift reports were conducted or documented. Additionally, the shift reports reviewed showed no evidence of training or process changes implemented from contamination issues identified in the case reports.					
	levels were mainta	d to ensure adequate staffing ined in the sterile processing for the number of surgical				
	#21 was observed procedure for Patie stated the procedu instruments going	44 a.m., operating room (OR) being set up for a surgical ent #12. OR Manager #5 re was delayed, awaiting through the sterilization of lack of staffing in the sterile ment.				

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	T OF DEFICIENCIES OF CORRECTION	PROVIDER IDENTIFICATION NUMBER:	MULTIPLE (BUILDING:	CONSTRUCTION	DATE SURVEY COMPLETED	
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H 503	Continued From pa	age 7	H 503			
	conducted with SP charge of the daily #3 stated the SPD Manager #3 report unsafe due to the lastated, on 2/28/18 a understaffed to per of the SPD process new staff and provieducation for curre Manager #3 provid of current job open listed as one super processing technic needed) technician On 2/28/18 at 9:35 Sterile Processing Supervisor #2 was stated the sterile prunderstaffed for the needing sterile sure #2 further stated the up on the amount of the department need instruments needed On 2/28/18 at 5:15 Sterile Processing conducted. SPT #1 department did not felt she was unable assigned tasks with On 3/1/18 at 2:05 p Nursing Officer (CN #7 reported she was staffing in the steril a couple of years, it	ed a copy of an online listing ings. Open positions were visor, five full-time sterile ians, and one PRN (as a.m., an interview with Department (SPD) conducted. Supervisor #2 rocessing department was a number of scheduled cases gical instruments. Supervisor e SPD was unable to catch of backlogged instruments in eding to be sterilized and the d for ongoing cases. p.m., an interview with Technician (SPT) #1 was stated the sterile processing have enough staff and she et to complete all of her				

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ent of Public Health and Environment

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H 503	financial officer after was conducted and needed 7 positions CNO #7 stated she chief medical office 50 surgical cases pafter the start of the the sterile processi with and the decision cases to a "manage current resources. was the first time s	e reached out to the chief er an evaluation of the SPD d determined the SPD filled. The had a discussion with the er (CMO #6) and decided the performed on 2/27/18 (5 days e survey) were too much for an department to keep up on was made to limit surgical eable workload" with their CNO #7 further stated this urgical cases were a SPD staffing issues.	H 503				
H 504	Process Continuous superv throughout receivir sterilizing, and stor or indicators shall beffectiveness of the Bacteriological metevaluate the effectiveness.	Supplies: Sterilization ision shall be maintained ag, cleaning, processing, ing. A combination of controls be used to determine the esterilization process. It should be used to veness of sterilization, by at res with records maintained.	H 504			06/27/2018	
	Based on observatinterviews the facilinstruments were pscheduled surgeriemanufacturer's instimaintenance of insto provide oversight			Tag H 504: Central Supplies, Ste Process Person Responsible: The Governing Body will have u responsibility for all corrective ac ongoing compliance associated	Itimate ctions and		

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Printed: 06/07/2019 Colorado Department of Public Health and Environment Health Facilities and Emergency Medical Services Division MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES PROVIDER IDENTIFICATION DATE SURVEY AND PLAN OF CORRECTION NUMBER: COMPLETED BUILDING: 060064 04/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2525 S DOWNING ST CENTURA HEALTH-PORTER ADVENTIST HOSPITAL **DENVER 80210** COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 504 Continued From page 9 H 504 immediate use steam sterilization (IUSS) and requirements, however the Chief Nursing the potential for transmission of healthcare Officer) CNO and Chief Medical Officer acquired infections. (CMO) provide direct oversight. The CNO and CMO collaborated Findings include: regarding when the sterilization process affected the availability of sterile Facility Policy: instruments for scheduled surgeries. The Perioperative Services Director has direct The Sterile Processing Procedures policy read, oversight of the Sterile Processing use of immediate use steam sterilization (IUSS) Manager, who is responsible for the will be kept to a minimum and only utilized in operational oversight of the SPD. selected clinical situations when there is Actions: 1. The Governing Board has full insufficient time to process by the preferred wrapped or container method. responsibility for determining. implementing and monitoring the Hospital's total operations and compliance Vendors will have checked in at the designated vendor management system kiosk, donned with its policies and procedures. appropriate ID and attire, prior to entering the Sterile Processing Department (SPD). 2. The Governing Board was informed of the outcome of accreditation surveys The Surgical Attire policy read, clothing including occurring 2/20/18 forward, via phone calls long sleeved garments that cannot be covered and meetings. The Governing Board held by surgical attire shall not be worn in the regular meetings and conference calls, restricted or semi-restricted areas. late February forward, to discuss the Non-scrubbed personnel should wear survey findings and the plans of long-sleeved jackets in restricted areas. A clean, correction. low lint surgical head cover that confines hair will be worn when in semi-restricted and 3. The Governing Board meets monthly restricted areas of the surgical suite. and as necessary to discuss overall operational and patient care issues. The Vendor Instrumentation policy read, all pans related but not limited to, effectiveness of must be received by 2:00 p.m. the day prior to sterilization. Hospital leadership worked

considered essential to patient safety were consistently addressed prior to procedures. The standardized list will include verification during

elements on the Surgical Safety Checklist were

selected to ensure that additional elements

surgery. Monday cases need to be received by

2:00 p.m. the Friday before surgery is

The Universal Protocol policy read, the

the time out that devices or special equipment are available.

scheduled.

sustain compliance. 4. Point-of-use pre-cleaning competencies began for all SPD and OR staffs on 2/22/18, including condition that instruments should arrive in SPD, and without gross contamination.

closely with Centura corporate leadership

to assist with correction of survey findings

and implementation of processes to

5. SPD staff trained on Stop-the-Line

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Printed: 06/07/2019 Colorado Department of Public Health and Environment Health Facilities and Emergency Medical Services Division MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES PROVIDER IDENTIFICATION DATE SURVEY AND PLAN OF CORRECTION NUMBER: COMPLETED BUILDING: 060064 04/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2525 S DOWNING ST **CENTURA HEALTH-PORTER ADVENTIST HOSPITAL DENVER 80210** COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 504 Continued From page 10 H 504 process, 3/7/18: any cart with visible gross References: bioburden is immediately rejected by SPD and leadership/ supervisor is notified According to The Association of Perioperative immediately. Registered Nurses (AORN), Guidelines for Perioperative Practice, 2017: 6. Requirement to follow IFUs when decontaminating/cleaning instruments was addressed by the contract IP, working Recommendation VII (Page 871), IUSS may be with observed SPTs, reminding them of associated with an increased risk of infection to patients and should be kept to a minimum. the requirement to follow the IFU for decontamination of each instrument. According to the Reliance Synergy Washer/Disinfector Operation Manual. 7. Gaps in education and documented maintenance procedures described in this sterile processing competencies were section must be performed as required at the identified. To address these gaps, a suggested frequency. Weekly routine cleaning surgical medical supply company, knowledgeable in surgical instrumentation procedures include cleaning the wash chamber rotary spray arm assembly, removing and cleaning, disinfection and sterilization, was cleaning the spray arms, cleaning the rotary contracted to provide spray arm assembly on accessories, the door retraining/re-validation of staff gasket, front panel, and the display. It is the competence for all components of the responsibility of the customer to perform the cleaning/ decontamination and decontamination of their unit once per week as sterilization processes, 2/28/18. Training instructed. Decontaminate and descale the included didactic and demonstration chamber using the DECONTAM cycle expressly components, completed 3/6/18. designed for this purpose. 8. A priority list of instruments/equipment 1. The facility failed to ensure surgical needed next/same day, was developed to instruments needed for surgeries were sterilized be followed by staff, and was mounted on and available for use at the scheduled start time a designated cart in Sterile Processing of patients' surgeries. Department (SPD). Staff review items on priority list, cross off and initial for a. On 2/27/18, a surgical case tracer scheduled completed task to inform other staff and for 7:30 a.m. was observed. At 6:55 a.m., reinforce the work was completed Certified Surgical Technician (CST) #10 stated 4/20/18. Daily huddles with OR Assistant she went to the sterile processing department Nurse Managers are held to review the (SPD) prior to setting up for the case and next day's priority list; this list given to instruments required for the current case were

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still cooling. CST #10 stated she frequently had to wait for instruments to be delivered from the

sterile processing department (SPD) at the start

At 7:34 a.m., OR Manager #5 called the SPD to

of the day.

SPD daily - 4/20/18.

mounted on 4/18/18 in the

9. A priority board was designed and

decontamination area to assist staff to

prioritize changing needs related to

instrument cleaning. Education to the

MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES PROVIDER IDENTIFICATION DATE SURVEY AND PLAN OF CORRECTION NUMBER: COMPLETED BUILDING: 060064 04/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2525 S DOWNING ST CENTURA HEALTH-PORTER ADVENTIST HOSPITAL **DENVER 80210** COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 504 Continued From page 11 H 504 ascertain when the instruments would be ready. board was completed 4/25/18 Manager #5 stated the staff member from the SPD she spoke with reported the instruments 10. A review of instrument washer would be ready for delivery to the OR suite in 10 maintenance requirements (review of to 15 minutes. At 7:50 a.m., 20 minutes after the IFU), was performed by the Director of Biomedical Engineering on 4/6/18. scheduled surgery start time, several surgical instrument trays arrived to the OR suite. 11. The manufacturer of the instrument At 9:30 a.m., a time out occurred with Vendor washer, Steris, came onsite to restore the #15 and all staff present in the OR suite. The instrument washers to operable condition entire team participated, including Vendor #15, on 4/6/18. SPD staff was retrained on the with no equipment comments or concerns descaling process on 4/8/18. identified. The time out included verbal verification that all sterilized instruments 12. Competencies related to ongoing washer descaling completed and required for the case were present. At 9:36 a.m., Physician #17 made the first incision. At documented by 6/8/18. 9:44 a.m., Vendor #15 brought another tray of surgical instruments into the OR suite and 13. The frequency of descaling of stated he had to wait for them to cool prior to washers was increased to at least bringing them into the operating room. When 3X/week, starting 4/7/18. The descaling asked about the late tray, Vendor #15 stated he of the washers is assigned to the SPD should have spoken up during the timeout to lead/Manager. Completion of descaling is notify the team that the tray was unavailable and documented on department log for each was still cooling in the SPD. washer. Visual inspection of the washer heater coils is completed weekly by the At 9:44 a.m., OR Manager #5 was interviewed SPD Manager or designee, starting and stated the facility's expectation was for all 4/9/18. The inspection is documented on needed surgical trays to be sterilized and department log for each washer. available prior to the patient entering the OR suite. Manager #5 further stated she would have 14. When discoloration on expected a discussion from Vendor #15 about instrumentation is observed, loads the delay of the surgical tray arriving to the OR (random packs and cassettes) from the suite during the time out. day the discoloration is noted will be visually inspected. Determine if discoloration is an isolated problem or On 2/27/18 at 4:05 p.m., CST #10 was interviewed. CST #10 stated she thought all of larger issue. If isolated, instruments are the necessary surgical instruments were in the reprocessed. Instruments may be sent to OR suite and available when the OR team the surgical medical supply company for refurbishing or to be retired at end-of-life. verified all instrumentation was in the room during the time out. CST #10 further stated all of the instrumentation needed for the procedure 15. If larger issue, the washer involved is should have been in the room prior to the shut down until the source of the problem incision. CST #10 stated that case carts were is determined. Episodes of instrument not always stocked properly because sterile discoloration or staining are reported to

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H 504	instruments were n needed. b. On 2/27/18 at 7:5 sterile OR corridor (instrumentation us involving structures undergoing an IUS: Further observatior corridor revealed at set undergoing an Ifor the same patient set. Registered Nutray from autoclave not ready when the start which required instruments. Scrub the instrument tray was not sterile at the During the observation Manager #5 confirm oculoplasty tray red sterilized by the SP time. c. On 2/28/18 at 11: Clinical Nursing Sp conducted. CNS #8 enough "man power resulting in instrum IUSS. CNS #8 cont not enough SPD st scheduled work load behind in sterilizing. CNS #8 stated the IUSS was due to the standard sterilization the surgical case to the surgical case to the surgical case to the surgical case to the standard sterilization the sur	ot ready when they were 30 a.m., an observation in the revealed an oculoplasty set ed for surgical procedures around the eyes) was S cycle in autoclave #9. In in the sterile operating room the ear, nose and throat drill USS cycle in autoclave #2 to awaiting the oculoplasty rese (RN) #11 removed the #2 and stated the tray was surgery was scheduled to be the use of IUSS for those Technician (ST) #12 stated required IUSS because it the beginning of the day. It in the sterile OR corridor, med the reason the quired IUSS was it was not ID in time for the surgery start in the sterile of the surgery start in the stated SPD did not have research to meet the work demand ents processed utilizing inued by stating if there was aff available to meet the d, they would always be surgical instruments. The interview with the stated SPD in time for the usage of the inability to complete a full on cycle in the SPD in time for time for the sPD in ti	H 504	the SPD Manager and Director of Perioperative Services for immeraction to identify the problem are action to identify the problem are 16. Episodes of instrument discording are documented and monitored in the occurrence repsystem, where they will be track trended. Outcomes of the Periodirector and SPD leadership's reand identified reason for the discoloration/staining are documented occurrence reporting system. Compliance and Monitoring: 1. Monitoring of IUSS rate and conducted monthly. Numerators of instruments/instrument sets resulus; denominator = number of cases with an IUSS target rate of to inadequately sterilized instrum (versus dropped or inadvertently contaminated during procedures. 2. Checklist procedure requiring double-check sign-off of scrub to other OR designee to ensure popre-cleaning and removal of grobioburden and spraying of instrumith enzymatic instrument spray check at point of departure from SPD is performed to ensure lack bioburden and presence of enzy spray. Fall-outs are entered into occurrence reporting system for and trending. 100% of carts are off at point-of-use and again at performed to SPD. Carts are moral teast 60 days, beginning 2/21/When 100% compliance is achieved.	diate ea. oloration orting ed and operative esponse nented in . reasons = number ecciving surgical of 5% due nents / s). ng ech and oint-of-use ss uments / c A final OR to c of gross / matic the review signed ooint of to nitored for /18.	
	of the surgical case would at times utilize	e, CNS #8 explained staff re IUSS and document the the "item was unsterile."		60 days, monitoring will transitio random audit of 75 case carts perfor one month. When 100% com	n to a er week	

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H 504	acceptable practice an emergency. d. A review of the II 2/28/18, revealed II instruments 60 time instances had the ras the item was unstances had the ras the item was unstated using IUSS instruments was no contamination of sutransporting them for operating room tab could also be assown was bioburden left. Director #4 added to need to have SPD schedule in order to instruments from the instruments for the the next day. Howe there had been no scheduling implements using IUSS (IP RN) #9. If acility followed AO perioperative area, minimized use of IU risks involved with standard sterilization contamination and IUSS should only be situations.	ded IUSS was not an and should only be used in and should only be used in USS logs, from 1/1/18 to USS was utilized on surgical es. During this timeframe, 21 eason documented for IUSS sterile. 17 p.m., an interview with as conducted. Director #4 to sterilize surgical of ideal due to the potential urgical trays when from the autoclave to the le. Director #4 stated IUSS ciated with infection if there on instruments. That she had discussed the staff participate in a flexible of finish processing the prior day, keep up with the current day and prepare for ever, Director #4 explained changes in SPD staff tented at the time of the Da.m., an interview was ection Prevention Registered PRN #9 confirmed the RN guidelines in the which included the USS. IP RN #9 stated the using IUSS, instead of the on process would be infection. IP RN #9 stated the used in emergency	H 504	is sustained for one month, an a random carts per month will occ month. 3. Monitoring of case start dela reasons. Numerator - # of case delays due to instrumentation; denominator = number of cases 0% delays due to instrumentation 4. Monitoring of failures in proper decontamination and/or steriliza as occurrence basis to ensure reaction is taken. Numerator = nur reported decontamination/sterilizaliures monthly; Denominator = of surgical cases performed moral a goal of 0% failure rate. 5. Incidents of instrument discorning system where they are and trended. Instances of this nareported in trended format month Quality Council, OR Committee, Governing Board. Target for discand staining on instruments, due reprocessing failures, is 0%. 6. Documentation of descaling visual inspection of washer coils monitored by the Safety Manage Department logs are monitored presence of documentation of comonthly with a goal of 100% corfor coil inspection and log comp Compliance will be reported monthe Quality Council, OR Commit Governing Board for 4 months a quarterly thereafter until Govern determines sustained compliance been achieved.	ays and start Target is on. Der tion on an emedial mber of zation enthly with coloration currence entracked ature are hly to the and coloration enthly to the and coloration enthly to the and swill be error hecks mpliance letion. In the coloration enthly to the and and ance		
		5 p.m., an interview with the r (CNO #7) was conducted.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PROVIDER IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION BUILDING:			DATE SURVEY COMPLETED	
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H 504	Continued From pa	age 14	H 504			
	turnover and leader contributing factors CNO #7 stated the leadership oversight turnover and had be 2. The facility failed machines were con accordance with machines were conducted with machines were conducted with machines (Manage to locate the Check (25 weeks). In addition 7/30/17 to 9/4.	ues with staffing, leadership ership oversight were all so for the routine use of IUSS. issues of staffing and hit were due to leadership over present for two years. If to ensure instrument washer insistently maintained in anufacturer's instructions. If Checklists utilized in the of 4/5/18 were requested for the manager of regulatory or #24) stated she was unable consistently tion, there were no checklists from 1/1/17 to 7/1/17 tion, there were no checklists from 1/1/18 to				
	tasks intended to be weekly basis by SF documentation of a of hard deposits for completed on the interpolation of	orgical case tracer scheduled observed. At 7:50 a.m., 20 cheduled surgery start time, oplied surgical instrument				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		PROVIDER IDENTIFICATION NUMBER:	MULTIPLE C BUILDING:	CONSTRUCTION	DATE SURVEY COMPLETED	
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H 504	Continued From p	page 15	H 504			
	incision. At 9:44 a another tray of verthe OR suite and to cool prior to bri room. At 9:44 a.m., OR and stated the factor needed surgical the available prior to suite. On 2/27/18 at 10:: Director #4 was of vendors were exprinstruments to the the day prior to the the day prior to the intended to be us vendors were tracked the facility throug Rep Tracks. Director ware of any and the order to be used to b	sician #17 made the first a.m., Vendor #15 brought in endor surgical instruments into stated he had to wait for them inging them into the operating Manager #5 was interviewed cility's expectation was for all rays to be sterilized and the patient entering the OR 27 a.m., an interview with SPD conducted. Director #4 stated bected to bring surgical e SPD no later than 2:00 p.m. he surgery in which they were ed. Director #4 stated that all cked when entering and exiting h a computer system called ctor #4 stated she was uditing done of vendor's work something the SPD could				
	revealed Vendor Patient #12's surg This was approxin 2:00 p.m. expecta instruments to the prior to procedure the standard steri 4. The facility faile followed facility p the sterile proces a. On 2/27/18 at 1 processing depar SPD Manager #3	ed to ensure outside vendors olicy regarding required attire ir				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PROVIDER IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION DATE SURV BUILDING: COMPL				
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H 504	surgical hair cover long sleeve shirt ur without a surgical sthe room briefly and cover on and a sur long sleeve shirt ard b. On 2/27/18 at 10 SPD Director #4 wistated the expectate surgical scrubs included and hair covers who Director #4 stated a with those requiremescorted out of the	and was not wearing a and was wearing a personal order a surgical scrub top crub jacket. Vendor #16 left dreturned with a surgical hair gical scrub jacket on over his order the scrub shirt. 27 a.m., an interview with as conducted. Director #4 ion was for vendors to wear uding a jacket, shoe covers ille processing instruments. any vendors not complying ments were expected to be	H 504			06/27/2018
	This REGULATION Based on observative the governing oversight of service to ensure they were and in accordance in the areas of surgicentrol, quality assimprovement and of Specifically the factive services were provestablished standard oversight of the steps of the s	ard shall:] all the functions performed I is not met as evidenced by: ions, interviews and record ing body failed to provide es provided within the hospital e provided in a safe manner with professional standards jical services, infection essment and performance		Tag H 606: Governing Board Responsibiltiy Person Responsible: The Governing Board will have responsibility for all corrective acongoing compliance associated requirements, however the Chie Officer) CNO and Chief Medical (CMO) provide direct oversight. The CNO and CMO collaborated discussions with the Governing regarding provision of services, contracted services, in a safe medical contracted services.	ctions and with these if Nursing Officer d in Body, including	

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References:

According to the Role and Responsibility Matrix,

the facility's board is fully accountable for

implementing, monitoring and evaluating the

quality of operating entity contracted services

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data are required to permit the Governing Board to make informed decisions related

to actions needed for improvements and

variability of process improvements. The

to understand rate, magnitude and

Governing Board also oversees and

directs the frequency and detail of

MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES PROVIDER IDENTIFICATION DATE SURVEY AND PLAN OF CORRECTION NUMBER: COMPLETED BUILDING: 060064 04/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2525 S DOWNING ST CENTURA HEALTH-PORTER ADVENTIST HOSPITAL **DENVER 80210** COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 606 Continued From page 18 H 606 and that any required improvements are improvement activities. integrated with the operating entity's quality 5. A review of Governing Board Bylaws program. and Responsibility Matrix to ensure Board According to the Quality Assessment, Patient understanding of roles and responsibilities Safety and Performance Improvement Plan, at the 5/24/18 Board meeting. dated 11/16/17, the facility will utilize information from risk assessments and ongoing data 6. The Board was educated per the analysis to make changes that will improve Matrix, that it is their responsibility to quality, performance and patient safety and ensure issues with contracted services reduce the likelihood and risk of sentinel events are monitored through the QAPI program. and other adverse events. Expectations of staff qualifications are outlined in contractual agreements According to The Association of Perioperative between providers and Porter Adventist Registered Nurses (AORN), Guidelines for Hospital and/or Centura. These include an Perioperative Practice, 2017: expectation that providers are compliant with state and federal law, regulation and Recommendation VII (Page 871), IUSS may be accrediting body requirements. associated with an increased risk of infection to patients and should be kept to a minimum. The Governing Board's overall evaluation of contracted services was 1. The facility failed to provide oversight of the reviewed at the 5/24/18 meeting of the sterile processing department (SPD) staff to Governing Board and will be reviewed at ensure equipment was completely cleaned, least annually thereafter, per policy. processed and sterilized appropriately by trained Ongoing review of contracted providers' and qualified personnel. performance is reviewed as a component of indicator monitoring, as scheduled, a. A review of the Sterile Processing through the hospital's QAPI program Department (SPD) Case Reports log from when indicated. 1/19/17 to 2/9/18 was conducted. During an interview with Clinical Nurse Specialist (CNS) The Governing Board evaluates #8, on 2/28/18 at 1:51 p.m., she stated the log contracted providers, including contracted contained data from SPD case reports which providers supplying personnel for were completed by operating room staff who compliance with the performance discovered an issue after the tray was delivered expectations of the contract. to the operating room (OR) suite. According to CNS #8 the reports were sent down to SPD and 9. The Governing Board evaluates the SPD manager created the log. contracted providers, including those supplying personnel, for compliance with Review of the Case Report log revealed 17 of performance expectations of the contract. 22 SPD staff members had one or more As part of the QAPI Calendar of incidents of documented contamination after the Reporting, contract service lists will sterilization process which included bone, hair, include an evaluation of their performance blood, and cement. As example, expectations. The Governing Board's

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H 606	total of 63 documer concerns with trays 2/9/18. From 1/19/17 to 3/2 reported incidents. contamination erro On 1/24/17 chunks pan. On 2/16/17 cement instrumentation. On 3/8/17 visible be the pan. On 3/22/17 bioburd surgical case. Subsequent to thes #13 received a writ of the corrective ac warning was issued meet the performal position. Specificall (spinal surgical instrument set durin noted on 3/7/17 the verbal warning reginstrument sets. After the corrective additional case repontaminated trays On 6/29/17 OR staff was found in the surgical instrument gun (surgical On 8/1/17 and 8/9/10 cement gun (surgical On 8/28/17 crusty be a surgical instrume On 9/6/17 cement won 1/22/17 blood for	Technician (SPT) #13 had a need incidents involving processed from 1/19/17 to 88/17, SPT #13 had 17 Five of the 17, were reswithin a surgical tray (pan). of bone found inside of the was found on the one and blood were found in en was found while in a se incidents, on 3/28/17, SPT ten corrective action. Review tion revealed, a written of for SPD#13's failure to nee expectations of his y, on 3/23/17 dirty Kerrisons truments) were found in an an angle a surgical case. The form the employee had received a parding dirty instrumentation in action SPT #13 had 11 orts that involved a carding dirty instrumentation in action SPT #13 had 11 orts that involved a dead bug argical tray. The cement was found on the all instrumentation). Blood or tissue was found on	H 606	overall evaluation of contracted was reviewed at the 5/24/18 me 10. Contract with a surgical mer supply company, knowledgeable surgical instrumentation cleanin disinfection and sterilization, to proceed the contracted SPD techs was mod 4/17/18, to remove requirement certification of techs. 11. When remedial actions for Scontracted provider staff member effective, the contracted staff member effective, the contracted staff member in the requested for termination. An instances of termination for performed a component of the contact evaluation. 12. Contracted SPD tech new havill be reviewed monthly for procompletion of initial, unit-based competencies. Contract SPD tenot be permitted to perform task independently until they are signated and competent lead tenot be permitted to perform task independently until they are signated and competent lead tenot be permitted to perform task independently until they are signated and competent lead tenot be permitted to perform task independently until they are signated and competent lead tenot be permitted to perform task independently until they are signated and competent lead tenot be permitted to perform task independently until they are signated and competent lead tenot be permitted to perform task independently until they are signated and competent lead tenot be permitted to perform task independently until they are signated and competent lead tenot be permitted to perform task independently until they are signated and competent lead tenot be permitted to perform task independently until they are signated and competent lead tenot be permitted to perform task independently until they are signated and competent lead tenot be permitted to perform task independently until they are signated and task independently in the performance of the performance of tenotons.	dical e in g, provide iffied on for SPD ers are not ember will by ormance ire files gress with chs will send off by ch. D and OR dition that D, without ne-Line sible gross ed by SPD tiffied when ments consultant is,	

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On 1/25/17 an instrument was noted as clogged

On 1/26/17 blood was found on a drill bit.

On 2/16/17 and 3/1/17 cement was found on

with the previous patients blood.

instrumentation.

developed to address variances in staffing

levels, immediate staffing needs and

volume and instrument inventory,

considered skill sets required, surgical

developed to staff SPD, 2/23/18, Staffing

levels reviewed, new SPD staffing matrix

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PROVIDER IDENTIFICATION NUMBER:		MULTIPLE BUILDING:	CONSTRUCTION	DATE SURVEY COMPLETED	
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H 606	found in the bottom On 4/21/17 blood w surgical instrument On 1/23/18 a piece bottom of the tray. d. Fifteen additional department (SPD) of the case report logging findings of contamination blood, and cement. e. On 2/27/18 at 10 SPD Manager #3 w stated "we are short processing instrum which he considered "I don't have enough processing departments of the contaminated trays operating room recomprocess had been of did not have time to staff completed the prior to the instruments of the contamination of the contamination of the contamination of the prior to the instruments of the prior to the contamination of the prior to the instruments of the prior of the prior to the instruments of the prior of	nown red substance was a for the tray. as found on top of spinal is (rainbow curettes). of bone was found in the all sterile processing employees were identified on its which identified similar nation, including bone, hair, it staffed" and we're currently ents for up to 50 cases a day and to be "not safe." He stated th staff" and the sterile ment was "severely short. The was aware there were still being delivered to the ently after the sterilization completed. He reported he is audit instruments after SPD in precleaning process and ents being sterilized. He satiffer an incident report to be staff to identify contaminated in the sterile in the sterile in the sterile in the sterile in the sterilization of the staff to identify contaminated in the sterilization in the sterilized. He satiffer an incident report to be staff to identify contaminated in the sterilized i	H 606	developed with consideration of volume times, staff skill sets and instrument availability. Staffing it by 7 FTE positions, 2/28/18. An and balanced staffing across sh accordance with work volume. Tincludes at least 2 individuals st decontamination to handle case starting 4/13/18. Balanced, final schedule created 4/20/18, including off-shift coverage. This "balance schedule is intended to smooth over all shifts and days of the woresponse to case volumes. 20. Emergency shift bonus pay on 2/21/18 to assist with immedistaffing requirements. Meetings Corporate resources to assist wimmediate response, 2/22-23/18 21. Ongoing collaboration continuentura, the hospital's corporate resources department, to active and identify qualified SPD technone SPD technician was hired a 4/24/18. 2 additional fulltime SP technicians will begin on 5/14/18 technicians will complete orienta 120 days, per policy. 22. Contracted agency supplies experienced and competent SP technicians; 8 open positions fill Travelers began 3/5/18 and are contracted through 7/12/18. 23. Experienced SPD Leads/Su were identified and scheduled, set 4/13/18, to provide 24/7 oversign decontamination and sterilizatio processes.	ncreased alyzed ifts in This affed in load, staffing ding eek, in instituted ate to identify ith 3. nues with e human ly recruit icians. as of D 3. New ation in 90-ed. currently pervisors starting at of
		I to ensure adequate staffing ined in the sterile processing		24. An experienced Interim Peri	operative

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Printed: 06/07/2019 Colorado Department of Public Health and Environment Health Facilities and Emergency Medical Services Division MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES PROVIDER IDENTIFICATION DATE SURVEY AND PLAN OF CORRECTION NUMBER: COMPLETED BUILDING: 060064 04/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2525 S DOWNING ST CENTURA HEALTH-PORTER ADVENTIST HOSPITAL **DENVER 80210** COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 606 Continued From page 22 H 606 department (SPD) for the number of surgical Director was identified on 3/4/18, to cases conducted. replace resigning Director 3/23/18. Interim dyad leadership structure created. a. On 2/27/18 at 7:44 a.m., operating room (OR) One leader specifically focuses on the #21 was observed being set up for a surgical operational oversight and accountability of procedure for Patient #12. OR Manager #5 the SPD processes and staffing to ensure stated the procedure was delayed, awaiting that sterile instruments are ready and available for scheduled cases. The other instruments going through the sterilization process, because of lack of staffing in the sterile leader focuses primarily on OR processes and operations. Position for permanent processing department. Perioperative Director and posted 3/19/18. b. On 2/27/18 at 10:27 a.m., an interview was 25. The Perioperative Services Director conducted with SPD Manager #3, who was in charge of the daily operations of SPD. Manager notifies senior leadership when insufficient #3 stated the SPD was "severely short staffed." SPD staffing may result in unavailability of instrumentation for scheduled procedures/ Manager #3 reported the sterile process was surgeries. The OR schedule may be unsafe due to the lack of staff. Manager #3 later stated, on 2/28/18 at 10:07 a.m., he was too adjusted, as needed - Ongoing. understaffed to perform duties to include audits of the SPD process, monitor occurrences, orient 26. An experienced Interim SPD Manager new staff and provided ongoing training and was hired through contracted agency, education for current staff. starting 4/10/18, to manage staffing and oversee sterilization processes. The On 2/28/18 at 9:35 a.m., an interview with sterile Interim SPD Manager reviews all processing department (SPD) Supervisor #2 occurrences and ensures staff is was conducted. Supervisor #2 stated the sterile coached/trained and that corrective action processing department was understaffed for the is taken when appropriate. The Interim number of scheduled cases needing sterile SPD Manager reports staffing issues that impact ability to process instrumentation surgical instruments. Supervisor #2 further stated the SPD was unable to catch up on the needs, to the Perioperative Services amount of backlogged instruments in the Director. department needing to be sterilized and the instruments needed for ongoing cases. 27. Position for SPD Educator posted 3/19/18 and an interim educator was hired, starting 5/29/18. The SPD Educator On 2/28/18 at 5:15 p.m., an interview with Sterile Processing Technician (SPT) #1 was assists with ongoing continuing education conducted. SPT #1 stated the sterile processing and competency assessment of SPD department did not have enough staff and she staff.

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Compliance and Monitoring:

1. Monitoring of IUSS rate and reasons

conducted monthly. Numerator = number

of instruments/instrument sets receiving

felt she was unable to complete all of her

#7 reported she was aware of inadequate

On 3/1/18 at 2:05 p.m., an interview with Chief

Nursing Officer (CNO) #7 was conducted, CNO

assigned tasks within her shift.

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sta a ha CI fin was need to che so afficial was read as a fold state of a so and a so a s	couple of years, be andle on staff turn NO #7 stated she nancial officer after as conducted and eeded 7 positions. NO #7 stated she nief medical office 0 surgical cases peter the start of the esterile processing ith and the decision as the first time subscheduled due to a the facility failed struments needed available for use the facility failed struments needed available for use patients' surgeries of 2/27/18, a surform 7:30 a.m. was onertified Surgical Tone went to the sterile SPD) prior to setting struments require ill cooling. CST #1 wait for instrume PD at the start of the transper #5 stated PD she speak without the start of the	e processing department for out the facility could not get a over since April of 2017. reached out to the chief of an evaluation of the SPD determined the SPD determined the SPD filled. had a discussion with the or (CMO #6) and decided the erformed on 2/27/18 (5 days of survey) were too much for one generated to limit surgical eable workload" with their CNO #7 further stated this surgical cases were sPD staffing issues. to ensure surgical defor surgeries were sterilized of eat the scheduled start time of eat the scheduled start time of the case and defor the current case were of stated she frequently had onts to be delivered from the	H 606	IUSS; denominator = number of cases with an IUSS target rate of to inadequately sterilized instrur (versus dropped or inadvertently contaminated during procedures. 2. Checklist procedure requiring double-check sign-off of scrub to other OR designee to ensure poper-cleaning and removal of grobioburden and spraying of instruction with enzymatic instrument spray check at point of departure from SPD is performed to ensure lact bioburden and presence of enzy spray. Fall-outs are entered into occurrence reporting system for and trending. 100% of carts are off at point-of-use and again at pure departure from the OR and prior transport to SPD. Carts are morat least 60 days, beginning 2/21. When 100% compliance is achief 60 days, monitoring will transition random audit of 75 case carts prior one month. When 100% contist sustained for one month, an arrandom carts per month will occur month. 3. Monitoring of case start delays due to instrumentation; denominator = number of cases ow delays due to instrumentation; denominator = number of cases ow delays due to instrumentation; denominator = number of cases ow delays due to instrumentation; denominator = number of cases ow delays due to instrumentation; denominator = number of cases ow delays due to instrumentation; denominator = number of cases ow delays due to instrumentation; denominator = number of cases ow delays due to instrumentation; denominator = number of cases ow delays due to instrumentation; denominator = number of cases ow delays due to instrumentation; denominator = number of cases ow delays due to instrumentation.	of 5% due ments / s) ng ech and wint-of-use ssuments / A final OR to cof gross // matic the review signed wint of review signed wint of review for no a ment of the ment of t	

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H 606	Continued From p	age 24	H 606		
H 6000	At 9:30 a.m., a timpresent in the OR entire team partici with no equipment identified. The time verification that all required for the callar. Physician #1 9:44 a.m., Vendor surgical instruments stated he had to with bringing them into asked about the lashould have spokenotify the team that was still cooling in At 9:44 a.m., OR Mand stated the factories and stated the factories Manager #5 expected a discuss the delay of the susuite during the time of the cooling that the necessary sur OR suite and avaitated the factories was suited all instruments.	e out occurred with all staff suite and Vendor #15. The pated, including Vendor #15, to comments or concerns e out included verbal sterilized instruments as were present. At 9:36 7 made the first incision. At #15 brought another tray of ats into the OR suite and vait for them to cool prior to the operating room. When ate tray, Vendor #15 stated he en up during the timeout to at the tray was unavailable and the SPD. Manager #5 was interviewed ility's expectation was for all ays to be sterilized and he patient entering the OR further stated she would have sion from Vendor #15 about urgical tray arriving to the OR		5. Monitoring of completion of counseling/corrective action in r to each identified failure. Numer number of corrective actions do related to failures monthly; Denormalized to courrence monthly, with a goal of 100% coongoing retraining and compete completion rate, for any SPD and not included in the initial training. 6. Rate of completion of new-rompetencies by 90-120 days, proceeding to the initial training for associates starting in Februar forward. This will be monitored for 4 months and quarterly there. 7. Daily monitoring of available matching the staffing plan. Numnumber of available SPD staff; Denominator = number of SPD required per the staffing plan, which compliance goal of 90%. 8. Monitoring of vacancy rate in the next year and quarterly there next year and year year.	rator = cumented cominator = elated to es mpliance. ency d OR staff g, is 100%. hire per policy, ary 2018, monthly eafter. e SPD staff erator = staff ith a monthly for eafter. sitions; epen
	should have been incision. CST #10 not always stocke instruments were needed.	in the room prior to the stated that case carts were d properly because sterile not ready when they were		9. Status of SPD staffing, per a reported to the Quality Council a Governing Board, monthly until Governance determines staffing not contributing to failures in sui instrumentation decontamination	levels are gical n and
	sterile OR corridor (instrumentation u involving structure	250 a.m., an observation in the revealed an oculoplasty set sed for surgical procedures as around the eyes) was mediate use steam sterilization		sterilization and that staffing has with a solid recruitment and rete program implemented. All data aggregated and reported month Quality Council, the OR Commit	ention will be ly to the

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H 606	corridor revealed a set undergoing an for the same patier set. Registered Nu tray from autoclave instruments was now was scheduled to struck the surgical case to instruments. CNS #8 stated the IUSS was due to the surgical case to instruments. CNS #8 stated the IUSS was due to the surgical case to instruments would would document the litem was unstered in the surgical case to instruments would would only be use	oclave #9. Further sterile operating room in ear, nose and throat drill IUSS cycle in autoclave #2 at awaiting the oculoplasty rise (RN) #11 removed the effect and stated the tray of ot ready when the surgery start which required the use of ruments. Scrub Technician in einstrument tray required as not sterile at the beginning attion in the sterile OR corridor, and the reason the quired IUSS was it was not in time for the surgery start. 54 a.m., an interview with ecialist (CNS) #8 was a stated the SPD did not have been to meet the work demand ents processed utilizing tinued by stating if there was aff available to meet the end, the department would in sterilizing surgical. main reason for the usage of the inability to complete a full on cycle in the SPD in time for the begin. If surgical to the sterilized by the start time end, the department who in the sterilized by the start time end to begin. If surgical to the sterilized by the start time end to t	H 606	Infection Prevention Committee Governing Board for a period of and quarterly thereafter until Godetermines sustained compliant achieved. 10. Monitoring of services furnishospital, whether or not they are under contract, are included in torganization's QAPI program, woutcome indicator reporting purthe monthly reporting schedule the service provided. Examples monthly compliance rates with psurgical instrument sterilization, staffing for SPD department fun IUSS rates and SSI rates. 11. The Governing Board review performance of contracted provability to meet the organization's performance expectations set for contract, including regulatory borequirements related to the provicare, treatment and services, horesources and medical staff requires appropriate to the service procontracted provider evaluation provided to the Governing Board annual basis.	4 months overnance ce is shed in the e furnished he with suant to related to include proper adequate ctions, where the state of the suant to include proper adequate ctions, where the state of the stat	

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H 606	Continued From p	page 26	H 606			
	instruments 60 tin instances had the as the item was u					
	SPD Director #4 v stated using IUSS instruments was r contamination of transporting them operating room ta	:17 p.m., an interview with was conducted. Director #4 is to sterilize surgical not ideal due to the potential surgical trays when from the autoclave to the ble. Director #4 stated IUSS ociated with infection if there it on instruments.				
	conducted with In Nurse (IP RN) #9. facility followed A perioperative area minimized use of risks involved with standard sterilizate contamination and IUSS should only situations; such a must be performe	00 a.m., an interview was fection Prevention Registered IP RN #9 confirmed the ORN guidelines in the a, which included the IUSS. IP RN #9 stated the utilizing IUSS instead of the cion process would be d infection. IP RN #9 stated be used in emergency a a life threatening surgery d and IUSS of instruments erform the surgery or a d and instrument.				
	chief nursing offic CNO #7 stated iss turnover and lead contributing factor CNO #7 stated the leadership oversion	25 p.m., an interview with the er (CNO #7) was conducted. Sues with staffing, leadership ership oversight were all rs for the routine use of IUSS. e issues of staffing and ght were due to leadership been present for two years.				
	for infection preve process for identif	ed to ensure staff responsible ention maintained a consistent fying, investigating and ntial surgical site infections				

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H 606	Continued From pa	age 27	H 606			
	revealed the patier facility for spine rel 11/9/17, Patient A variety surgeries which incomplete with interesting the spinal cord or recording to an Opphysician #21 on 1/2 computed tomogral large amount of succonsistent with an reported Patient A & D) procedure of wound. During the documented as who (containing pus) was surgical site. Samp the laboratory for compostoperative diagrocedure was docinfection. On 1/5/1 Disease Progress of the purulent fluice enterococcus faecicauses infections), antibiotics and discomplete for 2/20/18 at 2:04	a.m., Patient A arrived to the y department (ED) via chief complaint of back pain. Derative Note documented by /3/18 at 8:00 p.m., a phy (CT) scan identified a bcutaneous gas which was infection. Physician #21 had a incision and drainage (I the spinal surgical site I & D procedure, fluid hite, milky and purulent as found throughout the entire ples of the fluid were sent to diagnostic testing. The mosis after the I & D cumented as a postoperative 8 at 1:25 p.m., an Infectious Note documented the results of diagnostic testing identified alis (type of bacteria that Patient A was treated with charged to a skilled nursing 15/18.				
	the ED via ambular complaint of paraphody). According to documented by Ph Patient A underwe where a significant material was collected.	nce from the SNF with a chief legia (paralysis of the lower of an Operative Note pysician #22 at 5:00 p.m., and another I & D procedure of amount of infectious looking cited and sent for diagnostic the results of the diagnostic				

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H 606	Continued From p	page 28	H 606			
	(Vancomycin Res and staphylococc specimens obtain	enterococcus faecium sistant Enterococci or VRE) us on the intervertebral disc sed from the I & D procedure dition, Patient A's blood tested on 2/23/18.				
	at 4:04 p.m., she reports to track an infections. IP RN track and report of Healthcare Safety was made for all of tracked and investigations.	view with IP RN #9 on 4/11/18 stated she utilized multiple and investigate surgical site #9 stated she was required to sertain SSIs to the National A Network (NHSN). A request documentation of how she stigated possible SSIs and the etermine if they were reportable				
	utilized by IP RN: reporting of surgice showed she had in surgical site infect criteria for being re Healthcare Safety upon review of the	cument titled 2018 SSI and #9 to track investigation and cal site infections (SSIs), identified Patient A had a tion of the bone that met the reported to the National V Network (NHSN). However, e list of patients reported to Patient A was not listed as r having an SSI.				
	meeting criteria for the 2018 SSI doc	patients were identified as or having a reportable SSI on ument. Four of the seven documented as reported to 6, B, C, and D).				
	Quality (VP) #20 provided docume trending and report gathering the docume there were patien infections and should be a second to the control of the control	O p.m., Vice President of was interviewed. VP #20 ntation of the facility's tracking, orting of SSIs. She stated while umentation the facility noticed ts who had surgical site ould have been reported to to be to been, including Patient A. VP #9 had too many				

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STATEMENT OF DEFICIENCIES PROVIDER IDENTIFICATION NUMBER:		MULTIPLE (BUILDING:	CONSTRUCTION	DATE SURV COMPLE		
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H 606	Continued From pa	age 29	H 606			
	VP #20 acknowled investigation and to effective and they. She stated there we format and the indiprocess was not convestigate and tra	no standard tracking format. Iged the facility's current racking of SSIs was not had "had missed the boat." vas no standard tracking ividual responsible for the ompetent to identify, ck surgical site infections.				
	Quality (Director #2 she stated since be identified concerns program and was i some changes. Ho	w with the Interim Director of 28), on 4/12/18 at 8:55 a.m., ecoming the director she had s with the infection prevention in the process of making owever, Director #28 stated ted any changes at the time				
	site infections (SSI	tified an increase in surgical ls). However, the facility failed vith an action plan to decrease patient outcomes.				
	Committee minutes increase in hip and communicated to t 2017. The committ SSIs had not improthat an action plan monthly meeting him.	Infection Prevention s from 6/20/17 revealed an d spine SSIs was first the committee in January tee identified the rate of spinal oved since January 2017 and had been created and a ad been set up to regularly as of the action plan.				
	requested for revie provided which occ 5/17/17. The corpo patient safety (Dire there was no docu meetings and conf meetings held to re	n plan meeting minutes were ew. Only two meetings were curred on 5/10/17 and prate director of quality and ector #23) acknowledged mentation of monthly firmed there were only two eview the action plan.				
		interventions for reducing				

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H 606	Continued From pa	age 31	H 606			
	to the operating ro	e after the tray was delivered om (OR) suite. According to swere sent down to SPD and created the log.				
	Review of the case following. As exam	e reports showed the ple,				
	pan. On 1/25/17 an instruith the previous pon 1/26/17 blood von 2/16/17 cement instrumentation. On 3/8/17 visible bothe pan.	as found on a drill bit.				
	surgical case. On 4/21/17 blood was urgical instrument. On 6/1/17 an instrudried blood on it. On 6/28/17 black reinstrument. On 6/29/17, OR sta	ras found on top of spinal its (rainbow curettes). Iment was found to have esidue was found on an its documented a dead bug				
	a surgical instrumed On 11/22/17 blood was found on a piece on 1/23/18 a piece bottom of the tray. On 2/19/18 hair was instruments. On 3/12/18 bone we tray and "contamin On 3/29/18 "rust/bloon 4/2/18 question instruments which	plood or tissue was found on				
		cility identified 76 instances of ical instruments and trays,				

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H 606	Continued From prom 1/1/17 to pre	page 32 esent, which had been	H 606			
		O and sent to the OR suite to				
	Interim Director of the facility implem (LEAN project) to but she was not of During the project reviewed the Cast measure the succept defects (variation process. According aware the case result of the cast of t	rview, on 4/12/18 at 8:55 a.m., of Quality (Director) #28, stated mented an improvement project improve surgery delay times directly involved in the project. It the value optimization team see Reports as a way to clease of the project and identify ans) from the improvement and to Director #28 she was not exports existed and they were do to the quality department. The department will be acknowledged "we were not each on acting" on sterilization on the case reports as she was in.				
	conducted with the specialist (CNS # responsible for control and incidents involved instruments delived she noticed an information in IUSS cycles due department (SPD full standard sterified an incresing bioburden on the cement from a procession of the cement from a procession of the cement from the cement from a procession of the cement from the cement from a procession of the cement from the ce	1:54 a.m., an interview was be surgical clinical nurse (8), who stated she was ollecting data regarding IUSS olving the sterility of surgical ered to the OR. CNS #8 stated crease of instruments utilizing to the sterile processing (1) not having time to complete a lization cycle. CNS #8 also ease of incidents regarding gopened in the OR with m, specifically blood, bone or ior case. The notified her boss (Director dings in April 2017. CNS #8 EAN project was created lings of ongoing IUSS intaminated instruments. CNS				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		PROVIDER IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION BUILDING:		DATE SURVEY COMPLETED		
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H 606	Continued From page 33		H 606				
	project meetings, but was not aware of any ongoing discussions about the project since May 2017.						
	for employment in department (SPD) criteria agreed up facility and the SP deemed competer a. On 4/10/18 at 3 (SPT #25 and SP cleaning surgical decontamination robserved by a corconsultant (Consuwas conducting at	oom. The SPTs were also ntracted infection prevention altant #27), who stated she udits of SPTs performing amination, cleaning and					
	(spinal surgical insink partially filled solution. SPT #26 from Consultant # kerrisions for a ful accordance with t When SPT #26 was kerrisons, Consultant in SPT #26 was kerrisons.	erved scrubbing kerrisons struments) with a brush in a with water and enzymatic required verbal feedback 27 that he did not scrub the I minute which was in he manufacturer's instructions. as finished with cleaning the eant #27 instructed SPT #26 d to flush the instruments with					
	kerrisons with a b #25 required guide properly flushing a accordance with n	n observed scrubbing rush in the same sink. SPT ance from Consultant #27 on and rinsing the instruments in nanufacturer's instructions to the next step in the ng process.					
	an employment ag	ontract between the facility and gency revealed the agency facility with qualified SPTs					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		PROVIDER IDENTIFICATION NUMBER:	MULTIPLE (BUILDING:	MULTIPLE CONSTRUCTION BUILDING:		DATE SURVEY COMPLETED	
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H 606	Continued From page 34 internationally certified through the International		H 606				
	Association of Healthcare Central Service Material Management (IAHCSMM) or the Certification Board for Sterile Processing Distribution (CBSPD).						
	through the agency	5's personnel file, hired y, revealed no evidence he quired by the contract.					
		p.m., Manager #24 stated certified and did not meet the ne contract.					
	contracted SPTs (#showed that althouout a self evaluation facility had evaluate	nnel file review of five #25, #26, #29, #30, and #31) ugh each employee had filled on there was no evidence the ed the SPTs to ensure they duties there were assigned in occess.					
	(Cross reference 50	03, 504, 610 and 901)					
A 610	3.1 Qlty Mgt, Occ F	Rpt, PC-Qlty Mgt Prgm	A 610			06/27/2018	
	health care entity lide. Department pursual (a), C.R.S., shall est management progrand type of facility to patient or resident of complies with this Fresidences and corrections.	ram appropriate to the size that evaluates the quality of care and safety, and that Part 3. Assisted living mmunity residential homes cember 31, 2015, to achieve					
	Based on interview facility failed to mai program that identit	N is not met as evidenced by: ys and document reviews, the intain an ongoing quality ified and tracked quality data changes to improve patient		Tag A 610: Quality Management	t		

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Review of the case reports showed the

On 1/24/17 chunks of bone found inside of the

following, as example:

pan.

Quality Committee of the Board and the

5. Governing Board review of Board Bylaws and Responsibility Matrix to

Governing Board on 5/24/18.

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tracking and trending, as of 2/21/18.

11. Infection Preventionists (IP) are

reporting of SSIs. SSI data is reported up

responsible for infection data and

through the Infection Prevention

b. On 2/27/18 at 10:27 a.m. an interview with

SPD Manager #3 was conducted. Manager #3 stated "we are short staffed" and we're currently

processing instruments for up to 50 cases a day

which he considered to be "not safe." He stated

"I don't have enough staff" and the sterile

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A 610 Col	1EALTH-PORTE	R ADVENTIST HOSPITAL	2525 \$	FADDRESS, CITY, STATE, ZIP CODE S DOWNING ST FER 80210	
pro stat	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE DATE
			A 610	Committee OR Committee, Qua Council, and to Quality Committee	ee of the
cor	processing department was "severely short staffed." Manager #3 stated he was aware there were stil contaminated trays being delivered to the			Council, and to Quality Committe Board. The Governing Board will updated data at each meeting to their ability to monitor trends and	ee of the I receive o ensure d have
pro did stat pric stat con	ocess had been of not have time to aff completed the or to the instrumented he had to was	ently after the sterilization completed. He reported he audit instruments after SPD precleaning process and ents being sterilized. He ait for an incident report to be taff to identify contaminated in the sterilization.		oversight and responsibility for of the control of	oorting to the of nts, IUSS tivities
faci cor cor and	cility had identified ntamination withi rrective actions ir d patient safety a	s no documentation the d the ongoing issue of n SPD and implemented n order to improve quality and reduce the likelihood and nts and other adverse events.		undertaken to remediate inadeq instrument cleaning/sterilization Compliance and Monitoring: 1. Quality Council meets montl consistently, and follows the quareporting structure and Quality C of Reporting.	– 5/9/18 hly, ality
Inte the (LE but Dui rev	erim Director of C e facility implement EAN project) to in t she was directly wring the project the viewed the Case	ew, on 4/12/18 at 8:55 a.m., Quality (Director) #28 stated nted an improvement project nprove surgery delay times involved in the project. he value optimization team Reports as a way to ss of the project and identify		2. Data reported at Quality Correlated to surgical instrument ste Immediate Use Steam Sterilizati and Surgical Site Infections (SS reported from OR Committee and Committee and on to the Govern Board monthly.	erility, on (IUSS) I) is ad/or IP
"de pro awa not	efects" (variations ocess. According vare the case reported to the tooks and the case reported to the case reported to the case and the case and the case and the case and the case are case are case and the case are case a	s) from the improvement g to Director #28 she was not orts existed and they were to the quality department. the optimization team did		 3. IUSS rates reported to Infect Prevention Committee and to Qu Council monthly – initiated 4/25/ 4. OR/SPD monitoring dashbo 	uality 18.
not "sa effe issu	t look at the case afety lens." She a ective or efficient	reports with a patient cknowledged "we were not on acting" on sterilization the case reports and she		developed; process and outcom OR and SPD, including infection prevention-related data, is report Quality Council monthly – week 5/28/18.	e data for ted to
cor spe	nducted with the ecialist (CNS #8)	54 a.m., an interview was surgical clinical nurse, who stated she was ecting data regarding		5. NHSN Standardized Infection monitored.6. SSI data is monitored and remaining the standard s	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		PROVIDER IDENTIFICATION NUMBER:	MULTIPLE BUILDING:	CONSTRUCTION	DATE SURVEY COMPLETED	
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A 610	Continued From p	page 38	A 610			
	incidents involving instruments delive she noticed an incident IUSS cycles due to complete a full staff also identified regarding instrum	eam sterilization (IUSS) and gethe sterility of surgical ered to the OR. CNS #8 stated crease of instruments utilizing o SPD not having time to andard sterilization cycle. CNS an increase of incidents ents being opened in the OR them, specifically blood, bone prior case.		monthly to Infection Prev Committee, OR Committ Council and to the Gove quarterly as a componer infection prevention and processes.	nmittee and Quality Soverning Board onent of routine	
	#4) about her find further stated a LE related to the findi utilization and con #8 stated she had project meetings,	e notified her boss (Director ings in April 2017. CNS #8 EAN project was created ngs of ongoing IUSS staminated instruments. CNS attended the first few LEAN but was not aware of any ins about the project since				
2. The facility identified an increase in surgical site infections (SSIs). However, the facility failed to follow through with an action plan to decrease SSIs and improve patient outcomes.						
	Committee minute increase in hip an communicated to 2017. The commit SSIs had not import that an action plar monthly meeting h	Infection Prevention es from 6/20/17 revealed an d spine SSIs was first the committee in January tee identified the rate of spinal oved since January 2017 and had been created and a had been set up to regularly ss of the action plan.				
	requested for revi- provided which of 5/17/17. The corp- patient safety (Dir there was no documeetings and con	n plan meeting minutes were ew. Only two meetings were curred on 5/10/17 and orate director of quality and ector #23) acknowledged umentation of monthly firmed there were only two eview the action plan.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			MULTIPLE CONSTRUCTION BUILDING:		DATE SURVEY COMPLETED	
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A 610 Continued From pa	age 39	A 610				
identified possible is spinal SSIs, includitiming of preoperate proper aseptic tech opening sterile pace procedures, evaluate to patients' surgical cleaning of the OR were completed. The documentation to shad been implement for effectiveness. In 2018 SSI document identified with report 10/10/17 and 1/24/1 monthly action plan. On 3/1/18 at 11:00 and Infection Prevention conducted which reposition for 4 month not attended any mathematical plan since the position of the position plan since the position of the action plan since the position of the position of the action plan since the position of the position of the action plan since the position of the position of the action plan since the position of the position of the action plan since the position of the	ent interview, on 4/11/18 at 9 stated prior to February aware of the "problem" with "in shock" with the recent nated instruments sent to the OR. 749, 0941 and 0951) In Control: Providing Service ave an infection control le for reducing the risk of smitting nosocomial infections	H 901			06/27/2018	

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by surgical attire shall not be worn in the

will be worn when in semi-restricted and

restricted areas of the surgical suite.

long-sleeved jackets in restricted areas. A clean,

low lint surgical head cover that confines hair

restricted or semi-restricted areas. Non-scrubbed personnel should wear

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correction.

The Governing Board meets monthly

related but not limited to, effectiveness of

sterilization and infection control program

and as necessary to discuss overall

operational and patient care issues,

Health Facilities and Emergency Medical Services Division MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES PROVIDER IDENTIFICATION DATE SURVEY AND PLAN OF CORRECTION NUMBER: COMPLETED BUILDING: 060064 04/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2525 S DOWNING ST CENTURA HEALTH-PORTER ADVENTIST HOSPITAL **DENVER 80210** COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 901 Continued From page 41 H 901 and practices. Hospital leadership worked The Vendor Instrumentation policy read, all pans closely with Centura corporate leadership must be received by 2:00 p.m. the day prior to to assist with correction of survey findings surgery. Monday cases need to be received by and implementation of processes to 2:00 p.m. the Friday before surgery is sustain compliance. scheduled. 4. Instrument sterilization was The Universal Protocol policy read, the addressed through increase of SPD staff elements on the Surgical Safety Checklist were and SPD staff management. An Interim, selected to ensure that additional elements experienced SPD Manager was hired considered essential to patient safety were through a contract agency and began on consistently addressed prior to procedures. The 4/10/18 to provide review and oversight of standardized list will include verification during industry-standard protocols used for the time out that devices or special equipment decontamination and sterilization. The SPD Manager has responsibility for SPD are available. staffing and process, ensuring that The Surveillance policy read, data is collected instruments are ready for scheduled on all patients that meet the National Healthcare cases. Safety Network (NHSN) criteria for a hospital acquired infection. Surveillance information is 5. Staff scheduling was reviewed and also uploaded into the NHSN database as revised. Staffing has increased on all required by the Colorado Department of Public shifts. By 4/20/18 a balanced staffing Health and Environment. schedule was complete, including off-shift coverage. This schedule modified The Infection Prevention & Control Program coverage by developing a 6-week policy read, the committee shall oversee and schedule and adding experienced traveler review surveillance and reporting data of the SPD staff, trained and competent in facility's infection prevention and control decontamination and sterilization, as they program. The Infection Preventionist is are available and oriented. responsible for coordinating day-to-day services. To fulfill the purpose of this program, the 6. Immediate Use Steam Sterilization Infection Preventionist will develop and (IUSS) rates were reviewed and implement a targeted surveillance program and addressed at a monthly Surgery maintain current certification in infection Department Operating Review (DOR) prevention and control. meeting on 5/16/18, held by the Chief Medical Officer and the Director of Quality, which includes review of IUSS References: rates, occurrences and identifies According to The Association of Perioperative opportunities for IUSS reduction. Incidents Registered Nurses (AORN), Guidelines for of IUSS of implant are entered into the Perioperative Practice, 2017: occurrence reporting system for tracking

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Recommendation VII (Page 871), IUSS may be associated with an increased risk of infection to and trending.

7. SPD and OR staff initiated training

was still cooling in the SPD.

At 9:44 a.m., OR Manager #5 was interviewed

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were/are captured, trends identified and appropriately reported through NHSN and

the hospital's internal infection tracking

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H 901	needed surgical tra available prior to th suite. Manager #5 is expected a discuss the delay of the sur suite during the time On 2/27/18 at 4:05 interviewed. CST # the necessary surg OR suite and availa verified all instrume during the time out the instrumentation should have been i incision. CST #10 s not always stocked instruments were in needed. b. On 2/27/18 at 7:5 sterile OR corridor (instrumentation us involving structures undergoing an imm (IUSS) cycle in aut observation in the s corridor revealed a set undergoing an for the same patier set. Registered Nu tray from autoclave instruments was no was scheduled to s IUSS for those inst (ST) #12 verified th IUSS because it wa of the day.	ity's expectation was for all all all all all all all all all al	H 901	system. Daily positive culture reviewed, possible SSIs are flag based on symptoms and readm This process is a routine compothe Infection Prevention and Coprogram. 13. The National Healthcare Sanetwork (NHSN) definition and are followed for SSI and reporting Infections meeting NHSN criteria reported. 14. SSI surveillance letters were physicians who performed surge 7/17 to present, week of 5/14/18. 15. IP ensures consistent followidentifying, investigating and rep SSIs. A standardized SSI tracking was developed and implemente 5/8/18 and IP trained on system Pivot table to track/report to be to f 5/14/18 and future state solut track SSIs in EPIC (the hospital electronic medical record) is in development at the corporate leuronic medical record) is in development at the corporate leuronic medical record) is in development at the corporate leuronic medical record) is in development at the corporate leuronic medical record) is in development at the corporate leuronic medical record) is in development at the corporate leuronic medical record) is in development at the corporate leuronic medical record) is in development at the corporate leuronic medical record) is in development at the corporate leuronic medical record) is in development at the corporate leuronic medical record) is in development at the corporate leuronic medical record) is in development at the corporate leuronic medical record) is in development at the corporate leuronic medical record) is in development at the corporate leuronic medical record) is in development at the corporate leuronic medical record is in development at the corporate leuronic medical record is in development at the corporate leuronic medical record is in development at the corporate leuronic medical record is in development at the corporate leuronic medical record is in development at the corporate leuronic medical record is in development at the corporate leuronic medical record is in development at the corporate leuronic medical record is in development at the corporate leur	ged ission log. nent of introl fety algorithm ing criteria. a will be e sent to eries from i. up for iorting ing system d on 5/8/18. built week ion to s vel. e in SPD retained ed to the masis on strument r istent tions, per		
	Manager #5 confirr oculoplasty tray red	tion in the sterile OR corridor, ned the reason the quired IUSS was it was not PD in time for the surgery start		17. IP increased the rate of survithe OR with attention to the pre- of surgical instruments and in decontamination and sterilizatio	cleaning		

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MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES PROVIDER IDENTIFICATION DATE SURVEY AND PLAN OF CORRECTION NUMBER: COMPLETED BUILDING: 060064 04/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2525 S DOWNING ST **CENTURA HEALTH-PORTER ADVENTIST HOSPITAL DENVER 80210** COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION DATE **PREFIX** (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 901 Continued From page 44 H 901 as of 2/21/18. Surveillance includes time. review of precleaning/moistening of instruments at point-of-use in the OR, c. On 2/28/18 at 11:54 a.m., an interview with Clinical Nursing Specialist (CNS) #8 was decontamination processes, review of conducted. CNS #8 stated the SPD did not have SPD process and random selection and opening of surgical packs and sterilized enough "man power" to meet the work demand resulting in instruments processed utilizing cassettes/containers to identify variances IUSS. CNS #8 continued by stating if there was in SPD final output, Just-in-Time coaching not enough SPD staff available to meet the is provided to staff when appropriate. scheduled work load, the department would always be behind in sterilizing surgical 18. E-mail communication sent to all vendor representatives on 3/26/18, instruments. through RepTrax for mandatory re-acknowledgement and re-acceptance CNS #8 stated the main reason for the usage of IUSS was due to the inability to complete a full of Centura vendor management policies. terms and conditions including surgical standard sterilization cycle in the SPD in time for the surgical case to begin. If surgical attire. instruments were not sterilized by the start time of the surgical case, CNS #8 explained staff 19. Vendors were refreshed, on 3/26/18, would at times utilize IUSS and document the regarding the need to provide instruments reason for IUSS as the "item was unsterile." needed for the following day, no later than CNS #8 further stated IUSS was not an 2PM on the day preceding the planned acceptable practice and should only be used in surgery (or the Friday before the following an emergency. Monday). d. A review of the IUSS logs, from 1/1/18 to 20. When SPD verifies that drop-off 2/28/18, revealed IUSS was utilized on surgical timeframe expectations are not met, SPD instruments 60 times. During this timeframe, 21 notifies perioperative leadership to instances had the reason documented for IUSS determine if SPD is able to accommodate as the item was unsterile. late instruments in the SPD workflow. Perioperative leadership determines if the e. On 2/28/18 at 3:17 p.m., an interview with scheduled case may proceed or if it will be SPD Director #4 was conducted. Director #4 delayed/cancelled. stated using IUSS to sterilize surgical instruments was not ideal due to the potential 21. Perioperative leadership notifies Supply Chain Management when there is contamination of surgical trays when transporting them from the autoclave to the a need for vendor counseling. Supply operating room table. Director #4 stated IUSS Chain determines the need for and carries could also be associated with infection if there out vendor disciplinary action, for was bioburden left on instruments. example, suspension. Compliance and Monitoring: Director #4 added that she had discussed the 1. Daily monitoring of available SPD staff need to have SPD staff participate in a flexible matching the staffing plan. Numerator = schedule in order to finish processing number of available SPD staff:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PROVIDER IDENTIFICATION NUMBER:			MULTIPLE CONSTRUCTION BUILDING:		DATE SURVEY COMPLETED	
	060064				04/17/2	2018
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H 901	Continued From pa	ge 45	H 901			
H 901	instruments from the instruments for the the next day. Howe there had been no scheduling impleme survey. f. On 3/1/18 at 11:00 conducted with Infe Nurse (IP RN) #9. If facility followed AO perioperative area, minimized use of IU risks involved with standard sterilization contamination and IUSS should only be situations. g. On 3/1/18 at 2:05 chief nursing officer CNO #7 stated issuturnover and leader contributing factors CNO #7 stated the leadership oversight turnover and had be 2. The facility failed for infection preven process for identify reporting all potenti (SSIs). a. A review of Patier revealed the patient facility for spine relatively 17, Patient A was urgeries which incompared to the patient facility for spine relatively 17, Patient A was urgeries which incompared to the patient facility for spine relatively 17, Patient A was urgeries which incompared to the patient facility for spine relatively 17, Patient A was urgeries which incompared to the patient facility for spine relatively 18, Patient A was urgeries which incompared to the patient facility for spine relatively 18, Patient A was urgeries which incompared to the patient facility for spine relatively 18, Patient A was urgeries which incompared to the patient facility for spine relatively 18, Patient A was urgeries which incompared to the patient facility for spine relatively 18, Patient A was urgeries which incompared to the patient facility for spine relatively 18, Patient A was urgeries which incompared to the patient facility for spine relatively 18, Patient A was urgeries which incompared to the patient facility for spine relatively 18, Patient A was urgeries which incompared to the patient facility for spine relatively 18, Patient A was urgeries which incompared to the patient facility for spine relatively 18, Patient A was urgeries which incompared to the patient facility facil	e prior day, keep up with the current day and prepare for ver, Director #4 explained changes in SPD staff ented at the time of the detail at the	H 901	Denominator = number of SPD serequired per the staffing plan, with compliance goal of 90%. 2. Monitoring of vacancy rate of the next year and quarterly there Numerator = number of filled positions per staffing matrix, with compliance goal of 90%. 3. Status of SPD staffing, per able reported to the Quality Counce Governing Board, monthly until Governance determines staffing not contributing to failures in surinstrumentation decontamination sterilization and that staffing has with a solid recruitment and reterorgram implemented. 4. Checklist procedure requiring double-check sign-off of scrub to other OR designee to ensure popre-cleaning and removal of grobioburden and spraying of instrumith enzymatic instrument spray check at point of departure from SPD is performed to ensure lack bioburden and presence of enzy spray. Fall-outs are entered into occurrence reporting system for and trending. 100% of carts are off at point-of-use and again at present the open control of the open careful of the	nonthly for eafter. sitions; pen n a levels are gical n and stabilized nation gent and int-of-use ssuments and final OR to a of gross matic the review signed point of to	
	the spinal cord or n	ntions to release pressure on erves)m., Patient A arrived to the		transport to SPD. Carts are mor at least 60 days, beginning 2/21/ When 100% compliance is achie 60 days, monitoring will transitio	18. eved for	

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MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES PROVIDER IDENTIFICATION DATE SURVEY AND PLAN OF CORRECTION NUMBER: COMPLETED BUILDING: 060064 04/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2525 S DOWNING ST CENTURA HEALTH-PORTER ADVENTIST HOSPITAL **DENVER 80210** COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 901 Continued From page 46 H 901 facility's emergency department (ED) via random audit of 75 case carts per week ambulance with a chief complaint of back pain. for one month. When 100% compliance is sustained for one month, an audit of 75 According to an Operative Note documented by random carts per month will occur for one Physician #21, on 1/3/18 at 8:00 p.m., a month. computed tomography (CT) scan identified a large amount of subcutaneous gas which was Monitoring of failures in proper consistent with an infection. Physician #21 decontamination and/or sterilization on an reported Patient A had a incision and drainage (I as occurrence basis to ensure remedial & D) procedure of the spinal surgical site action is taken. Numerator = number of wound. During the I & D procedure, fluid reported decontamination/sterilization documented as white, milky and purulent failures monthly: Denominator = number (containing pus) was found throughout the entire of surgical cases performed monthly with surgical site. Samples of the fluid were sent to a goal of 0% failure rate. the laboratory for diagnostic testing. The postoperative diagnosis after the I & D 6. Monitoring of completion of procedure was documented as a postoperative counseling/ corrective action in infection. On 1/5/18 at 1:25 p.m., an Infectious relationship to each identified failure. Disease Progress Note documented the results Numerator = number of corrective actions of the purulent fluid diagnostic testing identified documented related to failures monthly: enterococcus faecalis (type of bacteria that Denominator = number of occurrence causes infections). Patient A was treated with reports related to SPD process fall-out antibiotics and discharged to a skilled nursing occurrences monthly, with a goal of 100% facility (SNF) on 1/15/18. compliance. On 2/20/18 at 2:04 p.m., Patient A returned to 7. Monitoring of IUSS rate and reasons the ED via ambulance from the SNF with a chief will be conducted monthly, including IUSS complaint of paraplegia (paralysis of the lower of implants. Numerator = number of body). According to an Operative Note instruments and instrument sets receiving documented by Physician #22 at 5:00 p.m., IUSS: denominator = number of surgical Patient A underwent another I & D procedure cases, with an IUSS target goal of 5% due where a significant amount of infectious looking to inadequately sterilized instruments vs. material was collected and sent for diagnostic dropped or inadvertently contaminated testing. On 2/23/18, the results of the diagnostic during procedures, and a target goal of testing identified enterococcus faecium 0% for implants. (Vancomycin Resistant Enterococci or VRE) and staphylococcus on the intervertebral disc 8. SSI data is tracked and trended, specimens obtained from the I & D procedure along with the NHSN SIR. on 2/20/18. In addition, Patient A's blood tested positive for VRE on 2/23/18. 9. Supply Chain monitors the SPD vendor sign-in form, for timeliness of b. During an interview with IP RN #9 on 4/11/18 vendor instrument set deliveries, and for at 4:04 p.m., she stated she utilized multiple compliance with surgical attire. reports to track and investigate surgical site

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STATEMENT OF DEFICIENCIES PROVIDER IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION BUILDING:		DATE SURVEY COMPLETED		
	060064				04/1	7/2018
NAME OF PROVIDER OR SUPPLIER CENTURA HEALTH-PORTER ADVENTIST HOSPITAL			2525 \$	FADDRESS, CITY, STATE, ZIP CODE S DOWNING ST FER 80210		
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H 901	track and report ce Healthcare Safety I was made for all do tracked and investic criteria used to dete to NHSN. Review of the docu utilized by IP RN #5 reporting of surgical site infection criteria for being re Healthcare Safety I upon review of the NHSN for SSIs, Pabeing reported for I Seven additional pameeting criteria for the 2018 SSI documpatients were not do NHSN (Patients #6 On 4/12/18 at 2:00 Quality (VP) #20 who provided document trending and report gathering the document trending and report gathering the document trending and shown NHSN but had not #20 stated IP RN # spreadsheets and to VP #20 acknowledginvestigation and the effective and they in She stated there we format and the indirection of	Stated she was required to rtain SSIs to the National Network (NHSN). A request ocumentation of how she gated possible SSIs and the ermine if they were reportable ment titled 2018 SSI and to track investigation and all site infections (SSIs), entified Patient A had a con of the bone that met the ported to the National Network (NHSN). However, list of patients reported to tient A was not listed as having an SSI. Attients were identified as having a reportable SSI on ment. Four of the seven ocumented as reported to p. B, C, and D). P.m., Vice President of as interviewed. VP #20 reation of the facility's tracking, ing of SSIs. She stated while mentation the facility noticed is who had surgical site alld have been reported to been, including Patient A. VP	H 901	10. IP surveillance conducted we compliance goal of 4 tracers a months, followed by 2X/month for months and at least quarterly the Outcomes of surveillance are communicated to OR and SPD weekly. 11. Data will be reported to the Committee, Infection Prevention Committee, Quality Council and Governing Body monthly, for a pronths and quarterly thereafter Governance determines that succompliance has been achieved.	nonth for 4 or 2 ereafter. leadership OR the period of 4 until	
	- anny an interview	the interim birector of				

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NUMBER:

Printed: 06/07/2019 Colorado Department of Public Health and Environment Health Facilities and Emergency Medical Services Division STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PROVIDER IDENTIFICATION MULTIPLE CONSTRUCTION DATE SURVEY COMPLETED

BUILDING:

		060064			04/17/2018	
	ROVIDER OR SUPPLIER	R ADVENTIST HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2525 S DOWNING ST DENVER 80210			
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PREFIX	Continued From paragraph Quality (Director #2 she stated since be identified concerns program and was in some changes. How she had not institute of the survey. 3. The facility failed ensure vendor loan delivered to the fact time required by fact a. On 2/27/18, a surfor 7:30 a.m. was o minutes after the so several vendor suptrays arrived to the At 9:36 a.m., Physic incision. At 9:44 a.m. another tray of vendor the OR suite and st to cool prior to bring room. At 9:44 a.m., OR M and stated the facilineeded surgical tra available prior to the suite. On 2/27/18 at 10:27 Director #4 was corvendors were experiments to the State of the Sta	ge 48 (8), on 4/12/18 at 8:55 a.m., acoming the director she had with the infection prevention in the process of making wever, Director #28 stated any changes at the time to provide oversight to ed surgical instruments were allity to be processed by the cility policy. Trigical case tracer scheduled beserved. At 7:50 a.m., 20 cheduled surgery start time, plied surgical instrument OR suite. Cian #17 made the first in., Vendor #15 brought in dor surgical instruments into ated he had to wait for them ging them into the operating anager #5 was interviewed aty's expectation was for all ys to be sterilized and e patient entering the OR Ta.m., an interview with SPD inducted. Director #4 stated cted to bring surgical SPD no later than 2:00 p.m.	PREFIX	(EACH CORRECTIVE ACTION SHOU	LD BE DATE	
	instruments to the Sthe day prior to the intended to be used vendors were track the facility through Rep Tracks. Director unaware of any auditors to the structure of the struct					

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	ATEMENT OF DEFICIENCIES PROVIDER IDENTIFICATION MULTIPLE CONSTRUCTION NUMBER: MULTIPLE CONSTRUCTION BUILDING:		CONSTRUCTION	DATE SURVEY COMPLETED		
		060064			04/17/2018	
	ROVIDER OR SUPPLIER	ER ADVENTIST HOSPITAL	2525 S	ADDRESS, CITY, STATE, ZIP CODE DOWNING ST ER 80210		
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H 901	Continued From pa	age 49	H 901			
	revealed Vendor # Patient #12's surge This was 76 minute expectation for ver the sterile process procedures to allow standard sterilization 4. The facility failed followed facility po the sterile process a. On 2/27/18 at 10 processing departs SPD Manager #3. setting up clean ins sterilized. Vendor # surgical hair cover long sleeve shirt un without a surgical sthe room briefly an cover on and a sur long sleeve shirt an b. On 2/27/18 at 10 SPD Director #4 w stated the expecta surgical scrubs inc and hair covers wh Director #4 stated with those requirer	d to ensure outside vendors licy regarding required attire ir ing department. 2:05 a.m., a tour of the sterile ment was conducted with Vendor #16 was observed struments in trays to be #16 was not wearing a and was wearing a personal nder a surgical scrub top scrub jacket. Vendor #16 left and returned with a surgical hair regical scrub jacket on over his				

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